HOUSE BILL 2041

By Mitchell

AN ACT to amend Tennessee Code Annotated, Title 56, relative to the reporting of certain health insurance information.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 2, Part 2, is amended by adding the following language as a new section:

56-2-127.

(a) As used in this section, unless the context otherwise requires:

(1) "Employer" means:

(A) Any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and

(B) Includes a group or association of employers acting for an employer in such capacity;

(2) "Governmental entity" means a state agency or political subdivision of this state;

(3) "Group health plan" means an employee welfare benefit plan as defined in § 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), compiled in 29 U.S.C. § 1002(1), including insured and self-insured plans, to the extent that the plan provides medical care as defined in § 2791(a)(2) of the Public Health Service Act (PHS Act), 42 U.S.C. § 300gg–91(a)(2), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

(A) Has fifty (50) or more participants as defined in § 3(7) of ERISA, compiled in 29 U.S.C. § 1002(7); or

(B) Is administered by an entity other than the employer that established and maintains the plan;

(4) "Health benefit plan issuer" means a health insurance issuer or a health maintenance organization;

(5) "Health insurance issuer" means an insurance issuer as provided in 45 C.F.R. § 160.103;

(6) "Health maintenance organization" means:

(A) A federally qualified health maintenance organization, as defined by 42 U.S.C. § 300e(a); or

(B) An organization recognized by Tennessee Code Annotated, Section 56-32-102, as a health maintenance organization;

(7) "Plan" means an employee welfare benefit plan as defined by 29 U.S.C. § 1002(1);

(8) "Plan administrator" means an administrator as defined by 29 U.S.C. § 1002(16)(A);

(9) "Plan sponsor" means a sponsor as defined by 29 U.S.C. § 1002(16)(B);

(10) "Political subdivision" means a county or municipality and their instrumentalities;

(11) "Protected health information" means individually identifiable health information defined by 45 C.F.R. § 160.103.

(b) This section applies to a governmental entity that enters into a contract with a health benefit plan issuer that results in the health benefit plan issuer delivering, issuing for delivery, or renewing a group health plan.

(c) For the purposes of this section, a health benefit plan issuer shall treat a governmental entity as a plan sponsor or plan administrator.

(d) A report of claim information provided under this section to a governmental entity is confidential and exempt from public records disclosure.

(e) No later than thirty (30) days after a health plan issuer receives a written request for a written report of claim information from a plan, plan sponsor, or plan administrator, the health benefit plan issuer shall provide the requesting party the report, subject to subsection (d).

(f) A report of claim information provided under subsection (e) must contain all the information available to the health benefit plan issuer that is responsive to the request made under subsection (e), including protected health information, for the thirty-six (36) month period preceding the date of the request or for the entire period of coverage, whichever is shorter. A report provided pursuant to subsection (e) shall include:

(1) Aggregate paid claims experience by month, including claims experience for medical, dental and pharmacy benefits, as applicable;

(2) Total premiums paid by month; and

(3) Total number of covered employees on a monthly basis by coverage tier, including whether coverage was for:

(A) An employee only;

(B) An employee with dependents only;

(C) An employee with a spouse only;

(D) An employee with spouse and dependents; and

(E) A separate description of any claim exceeding ten thousand dollars ($10,000), including the following information related to the claim:

(i) A unique identifying number, characteristic, or code;

(ii) The amounts paid;

(iii) Dates of service;

(iv) Applicable diagnosis codes; and

(v) Prognosis, or if not available, case management notes, including any future expected costs and treatment plan, that relate to the claim.

(g) A plan sponsor is entitled to receive protected health information under this section only after an appropriately authorized representative of the plan sponsor makes the following certification to the health benefit plan issuer:

"I hereby certify that the plan documents comply with the requirements of 45 C.F.R. § 164.504(f)(2) and that the plan sponsor will safeguard and limit the use and disclosure of protected health information that the plan sponsor may receive from the group health plan to perform the plan administration functions."

(h) If a request is received by a health plan issuer under subsection (e) after the date of termination of coverage, the report shall contain all information available to the health benefit plan issuer as of the date of the request, including protected health information, and including the information described in subsection (f), for the thirty-six (36) month period preceding the date of termination of coverage or for the entire policy period, whichever period is shorter.

(i) A report of claim information described in subsections (e) or (f) shall include the total dollar amount of claims pending as of the date of the report that were first filed during the twenty-four (24) month period preceding the date of the request or for the entire period of coverage, whichever is shorter.

(j) No later than thirty (30) days after the date of termination of coverage under a group health plan, a health benefit plan issuer shall provide to a plan, plan sponsor, or plan administrator who makes a request under subsection (e) before the date of termination of coverage a supplemental written report of the information described in subsections (e) and (f), including protected health information, to update the report of claim information with information that was not included in the original report.

(k) A plan, plan sponsor, or plan administrator may use information in a written report of claim information provided under this section only as necessary to perform treatment, payment, or health care operations as those activities are described in 45 C.F.R. § 164.501.

(l) No health benefit plan issuer that releases information, including protected health information, in accordance with this section shall be deemed to have violated a standard of care, be liable for civil damages, or be subject to criminal prosecution.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.